



Benefit Summary

BENEFIT LEVEL ~ KW

PHYSICIAN SERVICES

Office Visits for Illness or Injury	\$10 Copayment per Visit
Periodic Physical Exams, Well-Child Care, and Preventive Health Visits	\$10 Copayment per Visit
Immunizations	\$0 Copayment
Maternity Care, including Prenatal and Postpartum Care	\$0 Copayment
Professional Services that do not require a referral (e.g., anesthesiology, pathology, radiology)	\$0 Copayment
Professional Services which require a referral (other than Office Visits)	\$0 Copayment
Hospital and Skilled Nursing Facility Visits	\$0 Copayment
Allergy Services	\$10 Copayment per Visit \$0 Copayment for injections

OUTPATIENT, OFFICE LABORATORY AND RADIOLOGY

\$0 Copayment

PRESCRIPTION DRUGS (includes birth control pills)

Generic	\$5 Copayment per prescription
Brand	\$10 Copayment per prescription

Mail Order Service through Express Scripts

Up to a 34-day supply - one Copayment
A 35-90 day supply - two Copayments

EMERGENCY SERVICES

Hospital Emergency Room (In-Area) or (Out-of-Area)	\$0 Copayment when admitted to Hospital. \$50 Copayment per Visit for other use.
After Hours Clinic, or Freestanding Emergency Center (In-Area) or (Out-of-Area)	\$10 Copayment per Visit
Physician Services in conjunction with emergency care	\$0 Copayment

AMBULANCE SERVICES

Ground Ambulance Services	\$0 Copayment for immediate transportation in conjunction with an accident or other life-threatening situation, or when authorized in advance by HealthPlus. \$25 Copayment per occurrence for other use.
Air Ambulance Services	\$0 Copayment for immediate transportation when authorized in advance by HealthPlus.

HOSPITAL SERVICES

Inpatient Care	\$0 Copayment
Outpatient Surgery	\$0 Copayment
Other Outpatient Services and Supplies	\$0 Copayment

BENEFIT LEVEL ~ KW

MENTAL HEALTH SERVICES

When authorized in advance by HPM, and when under the direction or care of an HPM Preferred Mental Health Provider

Hospital Inpatient Care (Limited to 45 days per member per calendar year)	\$0 Copayment
Intermediate Care, including: 1. Day Treatment Program	\$0 Copayment
Outpatient Care (Limited to 20 visits per member per calendar year)	\$10 Copayment per Visit

SUBSTANCE ABUSE SERVICES

When authorized in advance by HPM, and when under the direction or care of an HPM Preferred Substance Abuse Provider

Hospital Inpatient Care	\$0 Copayment
Intermediate Care, including: 1. Day Treatment Program 2. Residential	\$0 Copayment \$0 Copayment
Outpatient Care	\$10 Copayment per Visit

HOSPICE	\$0 Copayment
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SKILLED NURSING FACILITY	\$0 Copayment
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PRIVATE DUTY NURSING	\$0 Copayment
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HEARING AIDS	\$0 Copayment
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DURABLE MEDICAL EQUIPMENT ORTHOTIC AND PROSTHETIC DEVICES	\$0 Copayment
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HOME HEALTH CARE	\$0 Copayment
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Not Covered:

- Services not provided or authorized by your primary care physician, except for emergencies
- Services and supplies that are not medically necessary, except checkups and related care to help maintain good health
- Dental care
- Cosmetic surgery
- Custodial care
- Eye glasses or contact lenses (except or the initial pair prescribed after cataract surgery)
- Exams for employment, licensing, insurance, travel, education, or sport purposes
- Services to the extent benefits are received or payable under Workers' Compensation, any insurance plan or state or federal laws
- Experimental treatments
- Vocational rehabilitation
- Personal or comfort items, such as television set or telephone
- Orthopedic footwear (unless attached to a brace, or outflow shoes)
- Sex transformation surgery and all expenses connected with that surgery
- Reversals of voluntary sterilization, all forms of in vitro fertilization, transsexual surgery, all services related to surrogate parenting arrangements, and all associated services and preparatory treatment related to any of the above. Artificial insemination is not a benefit except when approved by a Plan Physician for treatment of infertility
- Wigs or prosthetic hair
- Services or supplies from convalescent homes, homes for the aged, or adult foster care facilities
- Drugs, services, supplies provided on an outpatient basis and not specifically identified as being covered by the plan
- 24-hour skilled nursing care in the home
- Routine foot care

This summary of benefits and copayments has been prepared to serve as a quick and easy source of information about the health benefits provided by HealthPlus. It does not modify or take the place of the Subscriber Contract and/or applicable rider(s). Please refer to the Subscriber Contract and applicable rider(s) for a complete description of the specific benefits available. Services must be obtained from participating plan physicians and providers.